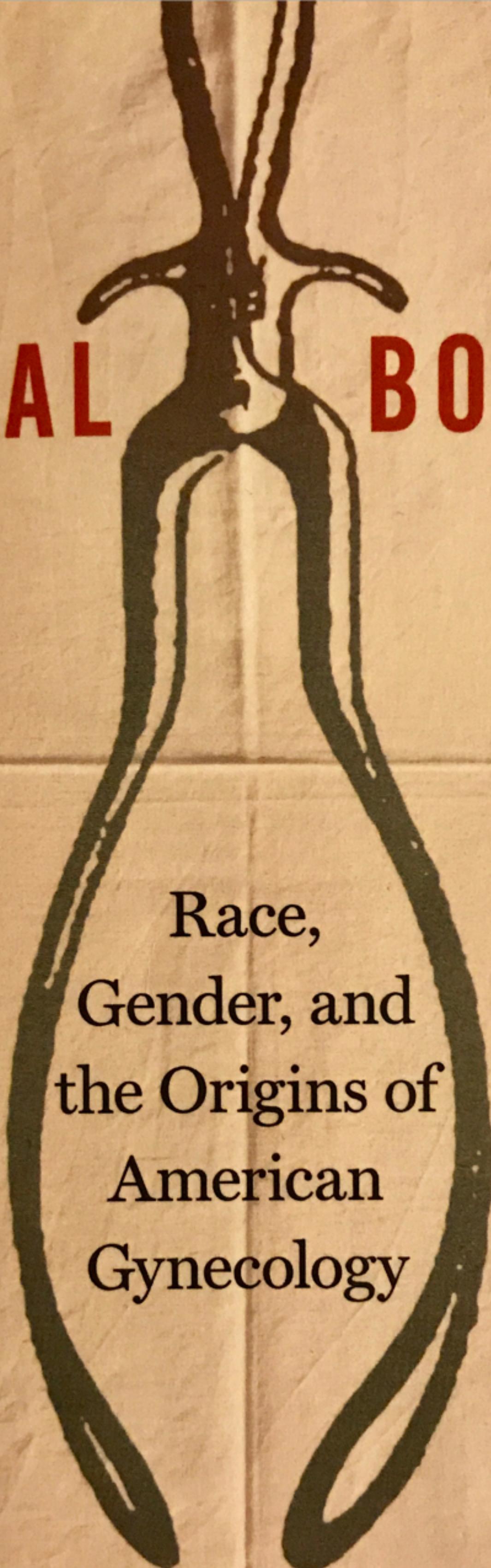


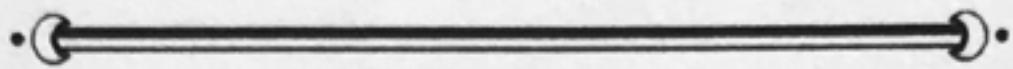
# MEDICAL BONDAGE



Race,  
Gender, and  
the Origins of  
American  
Gynecology

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## INTRODUCTION

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# AMERICAN GYNECOLOGY AND BLACK LIVES

When invoking the term “body,” we tend to think at first of its materiality—its composition as flesh and bone, its outline and contours, its outgrowth of nail and hair. But the body, as we well know, is never simply matter, for it is never divorced from perception and interpretation.

—Carla Peterson, *Recovering the Black Female Body*

THE FIRST WOMEN'S HOSPITAL IN THE UNITED STATES WAS HOUSED ON a small slave farm in Mount Meigs, Alabama, a lumber town about fifteen miles from Montgomery, a large slave-trading center. From 1844 to 1849, Anarcha, Betsy, Lucy, and about nine other unidentified enslaved women and girls lived and worked together in the slave hospital that Dr. James Marion Sims founded for his training and for the surgical repair of his patients. He had his workers, probably enslaved, build the hospital for the treatment of enslaved women affected by vesico-vaginal fistulae, a common obstetrical condition that caused incontinence, and that was brought on by trauma and by the vaginal and anal tearing women suffered in childbirth. Years after he performed his pioneering work, all experimental, Sims achieved success and an international good reputation. He would later be known as the “Father of American Gynecology.”

The women he operated on continued to perform the duties slaves were expected to complete. These bondwomen tended to the domestic needs of the Sims family, which included a sick child. They cooked, cleaned, stoked and kept the fire burning during the winter, fetched well water, wiped sweaty brows

and dried crying eyes, planted and picked vegetables, and nursed their babies, all while serving at the same time as experimental patients. As Sims's surgical nurses, they learned the fundamentals of gynecological surgery from arguably the most successful gynecologist of the nineteenth century. During the five years they lived on Sims's farm, they helped him birth a new field. It is no exaggeration to state that these enslaved women knew more about the repair of obstetrical fistulae than most American doctors during the mid- to late 1840s.

In studies of James Marion Sims's career and especially of his "Alabama years," the occupational status of his enslaved patients as nurses has been consistently overshadowed by discussion of their illnesses. This study of slavery, race, and medicine, on the other hand, makes a sustained effort to examine and understand the richness of the personal and work lives of slaves, especially of Sims's slave nurses. Their experiences offer us a lesson about the relationship between the birth of American women's professional medicine and ontological blackness. During the antebellum era, most American doctors believed that blackness was not only the hue of a person's skin but also a racial category that taught substantive lessons about the biology of race and the so-called immutability of blackness. Following this biological theory, a black woman could be the same species as a white woman but also biologically distinct from and inferior to her. By examining the work lives of enslaved women patients and nurses through the prism of nineteenth-century racial formation theory, we can better understand not only the science of race but also the contradictions inherent in slavery and medicine that allowed an allegedly inferior racial group to perform professional labor requiring substantial intellectual ability.

In the case of Dr. Sims's slave nurses, scholarship has examined their exploitation as patients forced to work as surgical assistants. This book, however, shifts the focus to the lack of recognition these women received as nurses, even though nursing was considered a feminine profession in which intelligence and judgment were valued. This book also demonstrates how slavery and racial science were self-contradictory in their assumptions about black people's inferiority. Although historical records list the New York hospital Sims founded in 1855 as the country's first women's hospital, we also know that a decade earlier he had created an Alabama slave hospital for women. During its last two years under Sims's leadership, he taught his patients how to assist him during surgeries. Once Sims left the South for New York, he sold his women's hospital to a junior colleague, Nathan Bozeman, Sims's former medical assistant and a fellow slave owner, who continued operating it as a gynecological hospital and treated and experimented on patients from a primarily slave population.<sup>1</sup> Like Sims, Dr. Bozeman later sold the hospital and returned the enslaved patients to their owners. He went on to advance his burgeoning medical career and

promote his button suture surgical method, which he touted as more successful than the Sims silk suture method.

For pioneering gynecological surgeons, black women remained flesh-and-blood contradictions, vital to their research yet dispensable once their bodies and labor were no longer required. Neither Sims nor other early American physicians viewed Sims's slave patients as the maternal counterparts to Sims in his role as the "Father of American Gynecology." There was no social or cultural impetus for professional white men, heavily invested in their racial, gendered, and slaveholding dominance, to do so. To remedy this failure to acknowledge their contribution, this book recognizes the unheralded work of those enslaved women recruited against their will for surgeries and made to work while hospitalized, and the labor of those poor immigrant women who willingly entered crowded hospitals in an effort to be healthy reproductively. *Medical Bondage* is not so much about historical recovery as it is about the holistic retrieval of owned women's lives outside the hospital bed. I place them in the annals of medical history alongside the doctors who performed surgeries on them.

Slavery forced sick women to experience their lives in ways unimaginable to other Americans. Slavery created an environment in which black women performed more rigorous labor than white women and some white men. Because the agricultural work that all enslaved people performed was identical, doctors sometimes erased gender distinctions when they assessed the physical strength and health of black women. White people believed that black women could sustain the brutal effects of corporal punishment such as whippings just as black men allegedly could. When these women fell ill, a physical state where most people are allowed to be weak, white society objectified and treated them as stronger medical "specimens." As a consequence, enslaved women vacillated between the state of victim and of agent.

The historical arc of American gynecology resembles other American histories in that it is triumphant. It is a polyphonic narrative that contains the voices of the elite and the downtrodden, and if studied closely, this history evidences how race, class, and gender influenced seemingly value-neutral fields like medicine. In works such as Sharla Fett's *Working Cures*, Marie Jenkins Schwartz's *Birthing a Slave*, and Deborah Kuhn McGregor's *From Midwives to Medicine*, enslaved women and Irish immigrant women emerge as historical actors worthy of examination. These scholars have rightly focused on sexual violence, reproduction, and the family, and *Medical Bondage* introduces both science and medicine into the discourse. By chronicling the lives of enslaved women, this book demonstrates that slavery, medicine, and science had a synergistic relationship. It departs from the work of Fett, Jenkins Schwartz, and Kuhn McGregor not only because it is a comparative study of black slave women,

Irish immigrant women, and white medical men. It also delves deeply into the creation of antebellum-era racial formation theories about blackness: the idea that race was biological and determined one's behavior, character, and culture.

Further, my study broadens the work of important historians of medicine like Todd Savitt who have focused on race and medicine but not examined the central role of slaves in the history of gynecology. Historians of race and medicine have recast different topics such as antebellum medical care, the health effects of emancipation, and late-nineteenth-century concerns about tuberculosis, race, and the city.<sup>2</sup> My work returns the discussion to the plantation while also examining how American gynecology developed.

*Medical Bondage* also builds on two significant arguments about the relationship between slavery and medicine. First, reproductive medicine was essential to the maintenance and success of southern slavery, especially during the antebellum era, when the largest migration and sale of black women occurred in the nation's young history. Doctors formed a cohort of elite white men whose work, especially their gynecological examinations of black women, affected the country's slave markets. Each slave sold was examined medically so that she could be priced. Second, southern doctors knew enslaved women's reproductive labor, which ranged from the treatment of gynecological illnesses to pregnancies, helped them to revolutionize professional women's medicine. Slave owners used these men's medical assessments to ascertain whether a woman would be an economically sound investment. Was she a fecund woman or infertile? Did she have a venereal disease that could infect others slaves on a farm or plantation? These questions mattered, and doctors provided the answers for buyers. Most pioneering surgeries such as ovariectomies (the removal of diseased ovaries) and cesarean section surgeries that occurred in American gynecological history happened during interactions between white southern doctors and their black slave patients.

As a comparative study, *Medical Bondage* analyzes the medical experiences and lives of Irish women during the antebellum era, in addition to those of slaves of African descent. This study does not consider the work lives of Irish immigrant women as maids, prostitutes, and factory workers in every aspect but focuses in particular on the medical impact that gynecology had on them. By the 1850s, the massive influx of recently arrived Europeans had become intertwined with modern American medicine. There has been little written about Irish women's reproductive medical lives, although many of these women experienced multiple pregnancies, like most American women of the antebellum era. This monograph shines a brighter light on the biomedical experiences of one of the largest groups of immigrant women in America during the age of slavery.

## CHAPTER TWO

### BLACK WOMEN'S EXPERIENCES IN SLAVERY AND MEDICINE

She died 'bout three hours after I was born. . . .

They made my ma work too hard.

—Edward De Biuew, formerly enslaved man

DECades out of slavery, Julia Brown explained to Geneva Tonsill, an African American Works Progress Administration (WPA) interviewer, how her former owner practiced medicine on his slaves.<sup>1</sup> Brown recounted, “He’d try one medicine and if it didn’t do no good he’d try another until it did do good.”<sup>2</sup> Brown’s account illustrates the risky and experimental nature of nineteenth-century American medicine. Further, the medical encounters she described also reveal the dimensions of slaves’ powerlessness against owners who took on the extra duty of caring medically for them. Julia Brown’s case is representative of that of any number of enslaved black women who were rendered unable to heal themselves as they wished. The medical experiences of Brown and other slave women symbolize the elasticity of early American medicine, a field that integrated both formal and informal practices. Medical doctors practiced medicine on black women’s bodies as did slave owners who formed close relationships with these medical men. Like trained physicians, Brown’s master risked killing his slaves in an effort to heal them. Julia Brown’s case illuminates how southern white men developed and deployed medical and pharmaceutical methods that revealed how the value of black people’s lives shifted back and forth like the measurements on a sliding scale.

The growing body of literature on U.S. slavery and, more specifically, scholarship on the medical lives of enslaved people describe in great detail how valuable black women’s reproductive labor was to both institutions. To birth a living and healthy black slave was rewarding for all members of slave communities including the mother, the plantation physician, and the slave owner. Each of these actors was invested in a slave child’s birth for varied reasons. The investment in protecting the worth of black babies is well documented in the slave narratives of former bondmen and bondwomen who recalled how expectant mothers protected the children in their wombs while receiving the lash. There are numerous judicial cases across slaveholding states that reveal how vested owners were in the reproductive health of black mothers and their unborn children. Last, in murder trials that involved pregnant enslaved women as defendants, execution dates were halted until their children were born.

Arkansan Marie Hervey, who lived on the Hess plantation in Tennessee, remembered how parturient women on the plantation were punished physically. She stated, “They used to take pregnant women and dig a hole in the ground and jut their stomachs in it and whip them. They tried to do my grandma that way.”<sup>3</sup> Had it not been for the efforts of her grandfather, who threatened those charged to whip his wife with violence, white plantation managers might have greatly harmed both mother and child. In an Alabama court case, *Athey v. Olive*, Littleton Olive bought a seemingly healthy pregnant slave, Matilda, from Henry Athey. Matilda’s baby died shortly after the sale. Olive sued Athey for five hundred dollars on the grounds that Matilda was not of “sound mind” and also that Athey had breached their contract.<sup>4</sup> Surely Matilda experienced a tremendous amount of stress as she endured removal from her home to a new slave community, pregnancy, and possibly other factors that remain unknown. Further, her new owner blamed Matilda for producing a stillborn.

*State of Missouri v. Celia, a slave* stands as one of the most infamous antebellum-era criminal cases focusing on an enslaved woman’s reproductive labor. The trial’s outcome demonstrates that the judicial system prized the woman’s pregnancy and unborn child rather than the teen mother who had been raped for five years by her late owner, Robert Newsome. Celia murdered Newsome, who had repeatedly raped her since she was fourteen years old. She had borne two of Newsome’s children and was pregnant at the time of his death. The local court found her guilty and sentenced Celia to death. They delayed her execution, however, until she could give birth to her baby. As disparate as these two examples seem, they encapsulate the totalizing and punitive effects of the “maternal-fetal conflict.”

Legal theorist Dorothy Roberts uses this term to describe the ways that laws, medical practices, and social policies differentiate between a pregnant woman's interests and those of her fetus. Roberts traces the genealogy of this conflict to slavery; of significance in her study are those cases where masters whipped enslaved women but shielded their bellies from the lash.<sup>5</sup> "Pleading the belly" was a process in English common law that allowed women in late-stage pregnancy to give birth before their death sentences were executed. Slave births created an incentive rooted in real property that merged with European religious and patriarchal notions that predated the institution of American slavery by centuries. Pregnant enslaved women lived in a society that invented and maintained practices that treated mother and child as separate entities. As a consequence, the mother's real value was in her reproductive health and her labor, which helps explain why reproductive medicine was so important during this era. White men with a stake in upholding slavery relied heavily on medical language and practices to treat and punish black women. Hence, slave owners and medical men upheld the practice of doing what they believed best medically to maintain a reproductively sound female slave labor force that was capable of breeding.<sup>6</sup>

The common linkage between the experiences of these enslaved women was their helplessness to resist the medical practices performed on their bodies. As much as enslaved women resisted their bondage and oppression, circumstances limited their power to defy their masters. Slavery and the antebellum-era medical field stripped slaves of agency at every turn, just as southern white babies suckled away the women's life-sustaining milk, a reproductive labor act that forced black mothers to provide calories for white infants' nourishment and growth at the expense of their own children's well-being. Slavery and the rise of American gynecology were the vessels that poured both life and death into black women's lives.

Although white medical men and many members of black communities expected these "manly" women or black "medical superbodies" to transcend fragility, many did not. The black female body was further hypersexualized, masculinized, and endowed with brute strength because medical science validated these ideologies. These myths led to the prevailing notion that enslaved women were impervious to pain. Tales abounded about black women's inability to feel physical pain. Delia Garlic recalled how shocked her mistress was when Delia fell unconsciousness after the mistress struck her atop the head with a piece of lumber. Delia stated, "I heard the mistress say to one of the girls, 'I thought her thick skull and cap of wool could take it better than that.'"<sup>7</sup> Former slave Harriet Jacobs shared in her memoir how her owner forced an enslaved woman to eat food that had killed his pet dog. The master did so because he believed that "the woman's stomach was stronger than the dog's."<sup>8</sup>

Further, the worries of bondwomen were rooted in the reality of the demanding physical labor they performed daily and the fear of the medical treatment they might receive as punishment. Edward De Biuew, who was formerly enslaved, suggested that his mother's premature death was caused by these factors. De Biuew remarked that his mother "died 'bout three hours after [he] was born" because "they made [her] work too hard."<sup>9</sup> William Lincrieux, an overseer who worked for Georgetown County, South Carolina, plantation owner Cleland Kinloch Huger wrote to his boss about how he continued to work two pregnant field hands who had tried to escape while laboring in Low Country rice paddies. On July 3, 1847, Lincrieux wrote that the parturient women were "confined which had done nothing in the hoeing of the Rice"; he made "no allowance . . . for sickness."<sup>10</sup> As much as enslaved women tried to resist their oppression, as the two parturient women had, they could do very little to protect themselves from the toll that field work took on their bodies. It is little wonder that enslaved women were at grave risk of suffering serious prenatal conditions. Prenatal risk was the price that slave owners, and by extension the doctors they hired to care for their female labor force, were willing to pay to ensure that black women continued to birth slaves with great frequency.

Motherhood was important to all women during the nineteenth century, but enslaved women's notions of motherhood and womanhood had linkages to the African continent. Enslaved women, who were descended from West and Central African ethnic groups, continued to incorporate the cultural practices that their foremothers had taught them about motherhood. These lessons ranged from how to suckle their children to how to wrap them in swaddling cloth while the mothers farmed plots of land. Also, because enslaved people could not legally marry and raise their children in the nuclear family model that was common for white Americans, motherhood took on special significance for black women in ways that marriage did not. Historian Andrew Apter discusses the importance of "blood mothers" in nineteenth-century Yorubaland, southwest Nigeria, and certain parts of Togo, Ghana, and Benin. Apter states, "The model of West African womanhood that took effect in the Americas is associated with the blood of mothers . . . that which gives them the ability to conceive and give birth."<sup>11</sup>

"Blood" served as a metaphor for West African mothers and their descendants who were born in America. It contained both good and bad essences and forged ties among black women that were both secret and sacred. Life and death were contained in the blood, from the release of menstrual blood and blood lost during miscarriages to the symbolic use of blood as a mode for purification.<sup>12</sup> For women who anticipated pregnancy and motherhood because of their significance in their conceptions of womanhood and also their self-

worth as fertile women, the intrusion in their lives of white southern men who replaced midwives compromised the deeply personal relationships they had with one another on an ancestral and a cultural level.

Black women viewed themselves as the cultural bearers of West African beliefs about motherhood, but they had to combat negative views that white physicians had about black women's bodies, especially their genitalia. Because doctors believed in the inferiority of women and the double inferiority of black women, they considered natural biological conditions such as menstruation pathological. In the same vein, they also determined that the clitoris was an underdeveloped penis.<sup>13</sup> In an 1810 medical article, Dr. John Archer asserted that the clitorises of little black girls were larger than those of their white peers because they accompanied their enslaved mothers to the fields while they worked. The doctors theorized that because these children sat unattended for long periods, their clitorises developed at a younger age.<sup>14</sup>

In the first half of the nineteenth century, deviancy seemed to define "femaleness." Sadly, this American conception of womanhood, health, and value precluded the importance of the West African "blood mother." It is from these seeds that modern American gynecology germinated into a branch of medicine adorned with both flowers and thorns. Like their peers in eighteenth-century Europe, antebellum-era American doctors who created gynecology began with the belief that "females in general were . . . a sexual subset of their race."<sup>15</sup>

Despite the general belief that black people, especially women, were inferior, the bodies of black women fascinated, as well as repulsed, white southern doctors. American slavery provided abundant opportunities for medical doctors to experiment on and sometimes heal sick bondwomen. Medical doctors happily engaged in experimental medical research that focused on restoring black women's reproductive capabilities, as the following examples illustrate.

In 1835, four doctors, John Bellinger, S. H. Dickson, T. G. Prioleau, T. Ogier, and two medical students, Mr. Tennent and Mr. Frierson, conducted an experimental ovarian surgery on a thirty-five-year-old black slave woman. She was to have an ovarian tumor removed.<sup>16</sup> The woman was the mother of one child, born seven years earlier; she had also suffered a number of miscarriages.

The previous year, the enslaved woman felt a lump on the right side of her abdomen, and since then she had been troubled with pain in her abdominal area. Doctors later diagnosed her as having a tumor. Right before Christmas, her team of doctors performed an ovariotomy to excise her tumor. During the surgery, the doctors realized there was "no opportunity for the safe use of the knife." One of the doctors recorded in his notes that the enslaved patient lost "her self-command, screamed and struggled violently—rendering it no easy

task to control her movements and support the viscera."<sup>17</sup> After physically restraining her, the doctors continued the operation. Her recovery was slow, and she later reported that she never again menstruated. Although the procedure had probably made her sterile, thereby decreasing her economic value, her diseased ovary, which was displayed at the Charleston, South Carolina, Medical College's museum, held greater worth for her doctors. This enslaved woman's diseased ovary would be used as a pedagogical tool and a medical curiosity.<sup>18</sup>

In a similar case a decade later, Dr. Raymond Harris, a Georgia physician, was asked by William Patterson, a slave owner in Bryan County, to examine one of his slaves. She had been experiencing uncommon symptoms during her pregnancy. After Harris probed the parturient woman, he found that she had "a large irregular tumor." The woman's menses had ceased for two years, and she had been constipated for months.<sup>19</sup> Harris operated on the thirty-six-year-old mother and determined that she had an ovarian pregnancy. He gave the bondwoman medicine, and her condition improved almost immediately.<sup>20</sup> After some time had elapsed, Harris wrote a medical article. In it he claimed that the enslaved woman's plantation owner and nurse had testified that the bondwoman had successfully regained her menses. Unfortunately, the enslaved woman began to experience the same symptoms she had manifested years before she became Dr. Harris's patient. Harris prescribed a potent dosage of medicine that included "iodide of potassium . . . in 5 gr. doses" to treat the enslaved woman's symptoms. She died shortly thereafter.<sup>21</sup> Upon learning of the woman's death, Harris stated, "Although it was late in the day, and myself much hurried, I requested permission to open the body."<sup>22</sup> He later lamented that he had not saved the enslaved woman's reproductive parts for preservation and study. For early gynecologists like Harris, even postmortem, a bondwoman's "real" value was still measured by her reproductive organs.<sup>23</sup>

Preserving diseased and damaged reproductive parts, performing experimental surgeries, and canvassing slave communities for sick patients helped southern doctors, medical colleges and museums, and their faculty and students advance their medical knowledge quite literally on the broken bodies of black slaves. Prior to the founding of the AMA in 1847, there was no single code of medical ethics. Systems of ethics regarding experimentation on the enslaved were idiosyncratic. In an 1826 issue of the *Philadelphia Journal of Medical and Physical Sciences*, Dr. P. Tidymen advised physicians who treated the enslaved that "it should always be left to the choice of the patient, to go into the hospital or be attended in his house. It [was] the interest and duty of the owner to consult the feelings of the slave."<sup>24</sup> Despite this seemingly polite ritual in southern manners, the practice, even if actually followed, rang hollow for enslaved patients if they did not know what the treatments would do to their

bodies. Unfortunately, the ideology of antiblack racism was too ingrained in the culture for southern physicians to heed Dr. Tidyman's admonishments. Even if an enslaved woman stated that she did not want to be operated on, once her owner granted permission to the surgeon to perform surgery, an operation occurred. Medical care of slaves evolved from its beginnings on slave ships to a mostly unregulated behemoth that tended to create "rules" as the field evolved.

Rules and ethical codes were created as new crises cropped up, and some early physicians and surgeons believed that the practice of slave medicine and, more particularly, human experimentation could lead to abuses by medical researchers. Antebellum-era physician William Beaumont created rules for medical research in 1833 "to provide an ethical framework for nontherapeutic trials."<sup>25</sup> Beaumont stipulated the following conditions:

1. There must be recognition of an area where experimentation in man is needed . . .
2. Some experimental studies in man are justifiable when the information cannot otherwise be obtained.
3. The investigator must be conscientious and responsible . . .
4. Whenever a human subject is used, a well considered, methodological approach is required so that as much information as possible will be obtained. No random studies are to be made.
5. The voluntary consent of the subject is necessary . . .
6. The experiment is to be discontinued when it cause distress to the subject . . .
7. The project must be abandoned when the subject becomes dissatisfied.<sup>26</sup>

Although experimentation on enslaved women was extensive, it was almost always therapeutic, since the goal was to enhance reproductive success. Broadly, most doctors who worked on slaves did so to protect, if not increase, the economic interests of slave owners and also to perfect their own skill set as doctors and physicians. The growth of gynecology provided for the maintenance of sound black female reproductive bodies; it also served to perpetuate the institution of slavery. Slavery, medicine, and capitalism were intimate bedfellows.<sup>27</sup>

Bondwomen were aware of their pecuniary worth in slave-trading transactions. They knew that potential slave owners had great interest in whether black women could breed with relative ease and also if they suffered from reproductive ailments that affected their fertility. Thus some enslaved women developed sophisticated measures to demonstrate some agency in their sale on auction blocks. Some would pass themselves off as healthy, even when they knew they had reproductive illnesses and sexually transmitted diseases that affected their fertility. One major advantage for enslaved women who employed this technique might be to escape mean owners, abuse, or simply especially grueling work schedules.

Warranty cases that featured the enslaved often bore these facts out in judicial court proceedings. Slave warranty cases based on redhibition, the legal template from which originated the "lemon laws" allowing legal action against the seller of a defective product, shed light on the various ways in which enslaved women dissembled to fool buyers and new owners.<sup>28</sup> Such a court case in South Carolina offers an example of a black woman's complicity in hiding her illness. In November 1821, a jury deliberated over the case of *Hughes ads. Banks*, in which the new owner of a slave woman, Mr. Banks, charged the previous slave master, Mr. Hughes, with willfully selling him a sick slave. According to court testimony, "Dr. Hammond . . . was called in to attend the woman. . . . About seven weeks after the sale, . . . [the woman became] excessively ill, and died on the next evening. . . . Hughes acknowledged that the woman had the venereal many years, (12 or 14) before, but had got entirely well; although some of her children had cutaneous eruptions, . . . easily cured."<sup>29</sup> The court found in favor of the defendant. Mr. Hughes received six hundred dollars and court costs for the death of the recently deceased slave woman, who was deemed "defective goods" largely because she had a sexually transmitted disease that affected her health and potential to reproduce.<sup>30</sup> Although the woman is rendered voiceless, it is highly improbable that she did not know that she had a sexually transmitted disease, one that she had for a number of years, as Dr. Hammond, the attending physician, noted. Records do not indicate why she remained silent about her disease, but it is unlikely that the disease manifested no symptoms, especially since her children had developed symptoms.

One year later in 1822, another South Carolina jury deliberated over a similar slave warranty case, *Lightner ads. Martin*, that concerned an enslaved woman who suffered from a sexually transmitted disease. The heart of the case centered on the following assertion: it was "alleged that one of the negroes 'had the venereal disease at the time of sale . . . that this woman had communicated the disease to others of his negroes, by which he had incurred a great loss and expense.'"<sup>31</sup> After the enslaved woman's owner contacted a physician to examine her, the bondwoman was given "a course of medicine" and became healthy. Her owner proceeded to sell her immediately.<sup>32</sup>

The *Lightner ads. Martin* case is distinctive because of the language used to describe the enslaved woman's illness and sexual behavior. Not only was the South Carolinian slave afflicted with a "venereal disease"; according to the language of the case, she was also promiscuous. Her promiscuity was such a threat to the health of the owner's other slaves that she was sold, even after she had been healed. This enslaved black woman's sexual power was perceived to be so potent that she was believed to be capable of creating life and destroying the reproductive value of black life simultaneously. Medical and legal writings

such as this one contained explicit language about how devious behavior was mapped onto black women's bodies. Alongside medical journals, judicial cases demonstrate the ongoing struggle of nineteenth-century Americans to define blackness within the realm of reproductive labor and sometimes to establish the sanity of enslaved people. In *Stinson ads. Piper*, the State of South Carolina declared that "a warranty of soundness embraces soundness of mind as well as body." This decision was made because of the questionable "soundness" of a recently purchased slave woman.<sup>33</sup>

The reach of southern medical doctors and slaveholders into black people's lives was so extensive and powerful that they could create illnesses linking the reproductive diseases of black people to their supposed degeneracy as women and mothers. In 1851, Dr. E. M. Pendleton of Hancock, Georgia, presented his research in "The Comparative Fecundity of the Black and White Races." Writing about black women, Pendleton reported, "The blacks are much better breeders than the whites." Yet the doctor offered a confusing reason for why enslaved women have more children: "Our negro females are forever drenching themselves with nostrums, injurious to their health and fatal to their offspring."<sup>34</sup> Despite black women allegedly poisoning themselves and their unborn children with dangerous potions, miraculously, they still managed to have more children than white women in Hancock County. These harmful beliefs represented black people's "soul murder."<sup>35</sup> Formerly enslaved Delia Garlic offered a poignant statement about white people's inhumane treatment of black people. Garlic pronounced, "It's bad to belong to folks dat own you soul and body."<sup>36</sup> Although she was not directly referencing gynecology's development and the research linked to it that understood black women as something other than normal human beings, Garlic's words are applicable to women's medicine.

Despite the ownership of black women's bodies by slave owners, enslaved women did resist the efforts of slave masters to lay claim to their "souls." They did so by sharing long-held folk wisdom and recipes that they used to heal members of slave communities. O. W. Green recalled how his grandmother, a slave nurse, passed along her medical and pharmaceutical knowledge to her family members. Green's grandmother provided thirty-seven years of service as a plantation nurse who doctored "all de young'uns" on the plantation. Green stated, "When old masta wanted grandmother to go on a special case, he would whip her so she wouldn't tell none of his secrets."<sup>37</sup> Although it was Green's grandmother who was giving medical care to patients, her white owner, who was also a doctor, took possession of her knowledge and touted it as his medical "secret" and inflicted corporal punishment on the woman to force her allegiance to him, "body and soul." Yet she defied her master in the privacy of her community and divulged her body of medical and herbal knowledge to her grandson.

Green disclosed his grandmothers "working cures" to his WPA interviewer, in a final act of ancestral defiance. She favored "black snake root, sasparilla, [and] blackberry briar roots" in her roots medicine practice, he told the interviewer.<sup>38</sup>

Although white men and black women were often in conflict over black women's medical treatments, in many instances, white men, both doctors and slave owners, also expected black women to treat expectant mothers and the infirm with the same body of knowledge that these men also derided. Dellie Lewis's grandmother, who was a plantation midwife, provides an example. Lewis revealed a favorite botanically based method that her grandmother employed when working on her parturient patients. The midwife blended a mixture of "cloves and whiskey to ease the pain" of childbirth.<sup>39</sup> Historian Sharla Fett has argued that bondwomen also resisted the wholesale control that slave owners and medical doctors had over their bodies. They "worked cures" noninvasively as they sought to establish a "relational view of healing" for themselves that privileged a more holistic model of healing.<sup>40</sup> Likewise, Julia Brown's narrative corroborates how enslaved women relied on and believed in the healing practices of granny midwives. Brown stated, "We didn't go to no hospitals as they do now. We just had our babies and a granny to catch 'em. We didn't have all the pain-easin' medicines. . . . The granny would put a ax under my mattress once. This was to cut off the after-pains and it sure did, too."<sup>41</sup>

Like enslaved women, most white Americans had little confidence or trust in professional medical care because of its invasive nature. They often became sicker or, even worse, saw their loved ones die under a doctor's care. Such poor outcomes are not surprising, given the haphazard nature of early American medicine. It was not governed by any national organization that created comprehensive regulations and ethical codes for doctors to follow. The AMA was not founded until 1847. One of its initial purposes was to standardize the qualifications of medical doctors. Before the AMA's creation, many men entered the field without formal educational training and little to no practical experience. American medicine harbored as many quacks as reputable health-care providers. For upwardly mobile young white men who bypassed either the ministry or law to practice medicine, their career choice was tantamount, in many regards, to throwing away their future and their respectability.

James Marion Sims's father initially scorned his son's decision to study medicine by stating that the field had "no science to it." To counter this notion, young men like Sims began to merge racial science with medicine as they engaged in experimental surgeries and published their results for the advancement of women's medicine. Dr. Sims's writings exemplify the cognitive dissonance that antebellum American medical men experienced as they wrote about enslaved patients and race. Although these doctors' publications were meant for

white audiences only, black people observed and responded to white doctors' participation in reproductive medicine. Most importantly, enslaved women's presence represented more than silent bodies on operating tables even if medical writings attempted to reduce them to one-dimensional objects.

Enslaved women knew that their lives were public and thus they had to protect what little privacy they had, especially with regard to their sicknesses. Thus black women rarely sought the services of white doctors. For those who did, the issue of the woman's consent to surgery was problematic. In the case of Mary, the black surgical patient whose womb Dr. Paul Eve excised, she was asked initially if she wanted to undergo surgery. Eve wrote, "Without persuasion or influence of any kind, she determined promptly and unhesitatingly to submit to the operation."<sup>42</sup> One might ask, however, if Mary, in antebellum-era Georgia, really had the choice of rejecting Dr. Eve's offer. By midcentury, it seems that black women, both free and enslaved, and white male doctors at least participated in a ritual of etiquette that afforded black women the pretense of having a choice about submitting to the proposed surgical procedure.

Within this extremely unequal power system was a parallel black medical practice that enslaved women were sometimes wily enough to engage; many times, however, it failed them. Fortunately, the oral histories of formerly enslaved women and men illuminate a complex medical past that has too often been shrouded in darkness. Their words reveal the myriad practices that black women used when caring for one another and their children. Fannie Moore told how her enslaved grandmother "worked cures" for the entire plantation community.<sup>43</sup> Moore told of how her grandmother used "roots and bark for teas of all kinds" to cure common illnesses. When she treated colicky infants, the elder Moore would "get rats vein and make a syrup and put a little sugar in it and boil it. Den soon as it cold she give it to de baby."<sup>44</sup> The enslaved and their enslavers moved uneasily between two worlds. One world was rooted in the here and now, where formally trained doctors consulted textbooks and articles on the diseases that affected black women and their children, while the other world relied on the folk knowledge and practices of enslaved women. These worldviews often clashed, but there were also synergistic moments.

In one of the earliest scholarly texts on the health of plantation slaves, historian William Dosite Postell wrote, "Uterine troubles were of common occurrence among slave women."<sup>45</sup> A May 1859 judicial warranty case that involved on a Louisiana bondwoman illustrates Dosite Postell's point. In *Gaienne v. Freret*, the plaintiff, Mr. Gaienne, had purchased an allegedly "sound" slave from Mr. Freret on February 3, 1859, in Louisiana. Two weeks after her purchase, the bondwoman alerted her new master that she was, in fact, not sound and suffered from a uterine disease. It was discovered that the woman

had an "ulceration of the uterus which she had carefully concealed from her former owner."<sup>46</sup> At Gaienne's request, four physicians examined the enslaved woman and recommended that Gaienne return her to her former owner, Freret, immediately. After the woman was returned to Freret's farm, she underwent another battery of "treatments," this time, in a local hospital.<sup>47</sup> Even though Freret believed that he had hired "skillful physicians" to treat his slave, the woman died soon after her stay in the hospital.<sup>48</sup> We will never know the specific reasons why this bondwoman concealed her uterine disease from her owners; it is conceivable, however, that she might have confided her physical status to one of the black women charged with caring for enslaved women on Freret's plantation. Enslaved women might have been terrified to disclose their health concerns to their owners, not only because of the issues surrounding gender but also because hospitals were often viewed with suspicion and considered sites of death. Historian Elaine Breslaw argues that "doctors carried an aura of death"; when called to assist nurses and midwives, enslaved women were no different in the way they viewed doctors: with great fear.<sup>49</sup>

As both the legal and the medical systems worked out the processes of how black women were to be defined and treated by doctors, jurists, slave owners, and southern society, individual American doctors were adding their perspectives to the discussion, medical case by medical case. Dr. John Archer cautioned physicians, and by extension, slave owners, who treated enslaved women medically to exercise vigilance in their treatments. Archer argued that if white medical men and slave owners did not prioritize the physical care of enslaved women, ultimately, black women would suffer from white men's neglect. He advocated for southern white paternalism without having to invoke the term "father." Thus medical journals could also encourage white men to serve as responsible providers for enslaved women. Archer believed that slave masters should be wedded not to principles of altruism but to practicality. The protection of a healthy black female labor force meant that slavery would not only survive but also thrive.

As the domestic slave trade flourished, enslaved women had to fight continuous intrusions into their reproductive lives. Medicine, especially gynecology, represented one of the largest encroachments black women faced, particularly because of the level of social control that doctors and hospitals exerted over them. Numerous medical journal articles described black failure and inferiority in wide-ranging ways. Doctors discussed the dirty appearance of black female bodies, the inability of black women to cook food properly for their families, and examined so-called black practices such as eating clay or dirt, also termed "cachexia Africana."<sup>50</sup> The reports and articles of these doctors continued to promote a general belief that blackness was unclean and caused

disorderliness and that black bodies were vectors of disease. Black people and their “race” represented an oppositional framework for whiteness as represented in American society. Therefore, the ideology of white paternalism aided gynecology’s growth by laying claim to black women’s reproductive bodies, both metaphorically and literally.

The writing of Kentucky physician John Harrison demonstrates how the presence of white male doctors contributed to furthering ideas about black women’s inadequacies as healers. In the opening sentence of Harrison’s 1835 article, “Cases in Midwifery,” he wrote, “This was a badly managed case at first; for an old ignorant negro midwife had been the first assistant of nature.”<sup>51</sup> He was condescending in his description of the “ignorant” black midwife who was involved in an extremely difficult obstetrical case. Five years earlier, Harrison had treated a black patient who was caught in limbo, trapped between life and death. He graphically described a ghastly scene in his article. On December 23, 1830, Harrison “found a black woman . . . lying in bed . . . with part of the forearm and hand of the child hanging out of the vulva.” He directed the woman’s husband and her elderly enslaved midwife to separate and hold up her legs so that he could deliver the woman’s baby.<sup>52</sup> Harrison described the black midwife as inadequately prepared to handle her patient’s obstetrical condition, although he had to rely on her assistance during the delivery. Harrison, as a product of the slaveholding South, knew that it was common practice for a slave midwife to deliver enslaved children. The rules created by white supremacy dictated that only a black woman could serve as the “first assistant of nature” in a slave woman’s delivery. He was simply finishing a job that the nurse had begun earlier. Harrison’s journal article helps to explicate the vulnerability of enslaved women in their roles as patients and nurses.<sup>53</sup>

Black midwives had to serve the interests of slave owners and, later, physicians by acquiescing to the complete authority that these men exercised over them and their charges. As white men became involved in midwifery cases, black midwives began to bear physical witness to the surgical treatment and repair of enslaved women who had given birth. Midwives had always relied on unobtrusive tools to birth babies. When white men integrated obstetrics and gynecology, pregnant enslaved women who experienced difficult birthing processes became disproportionately represented in surgical cases in which doctors used blades and forceps to remove fetuses. Surgeries were quite rare in the first half of the nineteenth century, so it is astounding how many medical journal articles listed enslaved women as surgical patients. Although the archival sources do not provide precise figures for the number of gynecological surgeries performed during the nineteenth century, one can assume that these sorts of operations occurred with more frequency than has been reported.

## CHAPTER THREE

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### CONTESTED RELATIONS

#### *Slavery, Sex, and Medicine*

Before striking me, master questioned me about the girl. . . . I only knew that she had been with child, and that now she was not, but I did not tell them even of that.

—Mrs. John Little, recounting her silence about a bondwoman's abortion

**I**N AUGUST 1831, A YOUNG ENSLAVED GIRL, OWNED BY MRS. LEGAY OF Christ Church Parish, South Carolina, underwent one of the most traumatic experiences imaginable: an enslaved man brutally raped and sodomized her. The slave girl's physical damage was so extensive that she was unable to urinate for a week after her rape, her anus was excoriated, and she experienced symptoms similar to dysentery—severe diarrhea with either blood or mucus in the feces. As many victims of rape do, she kept the tragic event hidden until her body revealed the secrets she had held on to in silence.<sup>1</sup> The girl's health continued to deteriorate quickly, and her owner summoned Dr. R. S. Bailey to treat her. After Bailey's examination, the young girl revealed the details of her rape, identified her rapist, and told the doctor that he "had since absconded."<sup>2</sup>

The sexual exploitation of enslaved women often worked in tandem with physicians' medical explorations and publications that medicalized sexual assaults and their physical effects on women. In an effort to illustrate this claim, this chapter draws on several oral histories of former slaves, medical case narratives, slave owners' personal papers, and judicial cases. In the case of Dr. Bailey's patient, her life is representative of the harrowing experiences that many female slaves endured. This black girl, who was never safe from either black

or white male intrusion, shows how deeply sex, slavery, and medicine were entangled in nineteenth-century America. Black women's rapes, which were private occurrences, were publicized when members of the slave community reported illnesses to one another, owners, and doctors. Additionally, doctors created professional spaces such as medical journals, teaching hospitals, and colleges where the physical symptoms of these assaults were medicalized. The publication of slave women's rapes in medical writings allowed doctors to learn how to respond to the physical symptoms of sexual assault, such as pregnancy, infertility, venereal disease, and damaged reproductive organs.

Thus when medical men like Dr. Bailey prescribed chemically based medicines for their patients, they were applying the pharmaceutical training many American doctors received in medical colleges. In the case of Bailey's young patient, he gave her a mixture of 3.58 grams of crushed cinchon (an ingredient used to make quinine), 1.79 grams of saltpeter (potassium nitrate), and 2 grams of pulverized opium to treat her symptoms.<sup>3</sup> Cinchon aided nausea, opium led to constipation, and saltpeter helped to ease painful urination. Bailey may have included saltpeter in his prescription because American doctors had been giving the medicine to patients suffering from venereal diseases such as gonorrhea and syphilis since the beginning of the century. A common symptom of gonorrhea and syphilis was urethritis, the medical term for an inflammation of the urethra that causes difficult urination.<sup>4</sup> Most importantly, Bailey pathologized rape and also included black women and girls as victims of rape in a leading medical journal published in a state where they were not legally protected from sexual assault.

Conversely, members of the slave community who lived alongside the victim, particularly black women, would certainly have recognized that the girl had been raped and attempted to comfort her after such a traumatic event. Although Bailey's journal article is silent on what actions black women took to care for this victim, historical literature on slavery offers abundant examples of the maltreatment young black rape victims received from their owners, mistresses, and doctors. The following case highlights the danger black girls faced from white women who discovered their husbands' sexual abuse of female slaves. Thirteen-year-old Maria's mistress caught her in bed with her husband, the girl's master. Upon discovery, the master escaped, and the mistress beat Maria and later had her imprisoned in a smokehouse for two weeks. Older enslaved women pleaded on behalf of the teen girl but were unable to convince their mistress of Maria's victimization.<sup>5</sup> Unlike Maria, Bailey's young enslaved patient was not only regarded as a victim of a brutal rape but also given medical treatment. Sadly, despite the doctor's care and the outpouring of support she received from her community, the girl "died soon after" the rape and subsequent

medical intervention made to save her.<sup>6</sup> Both her medical case and her death function as a potent reminder of the complexities of sex, slavery, and medicine in the antebellum South for young black girls and women.

Acclaimed ex-slave memoirist and abolitionist Harriet Jacobs wrote, "The secrets of slavery are concealed like those of the Inquisition."<sup>7</sup> Jacobs used a stark metaphor to describe the horrors she had experienced as an enslaved woman. She wrote that she lived "twenty-one years in that cage of obscene birds" while under the auspices of her master.<sup>8</sup> In this phrase, Jacobs captured the panic that black women faced as they were subjected to the whims of masters who were often "obscene" in their interactions with black women.

The sexual abuse of black women was also an intraracial problem. Scholarly discussions of enslaved men's rape of black girls and women have not been entirely muted; however, scholars need to more fully examine intraracial sexual abuse within slave communities. Two other sites that reveal the inner sexual lives of enslaved women are nineteenth-century medical journals and judicial court records. These sources show how physicians and justices treated intraracial sexual violence within enslaved communities. Enslaved women and girls were vulnerable to attack from white and black men with whom they came into contact. Black women had not only to contend with men who preyed on them but also to fight against the ugly stereotypes that many American men, regardless of race, held about them as wanton seductresses. Robert Smalls, who was born enslaved and later became Reconstruction-era South Carolina's most famous black senator, offered his views on black women's sexual promiscuity to an American Freedmen's Inquiry Commission member after the Civil War. When his interviewer asked Smalls whether black women were full of lust, he answered affirmatively. Smalls also stated, "[Black women] do not consider intercourse an evil thing. This intercourse is principally with white men with whom they would rather have intercourse than with their own color. The majority of the young girls will for money. . . . as young as twelve years."<sup>9</sup> Although the scholarship is slim on this topic, Robert Smalls's views on black women's lustfulness and their supposed preference for engaging in interracial sex for profit, postwar, without regard for their physical and emotional well-being, chastity, and reputations indicate that the sexual terrain for enslaved girls and women was paved with steep hills. Ideologies are formed over time, and Robert Smalls's beliefs probably did not originate solely in the post-1865 racial milieu but were formed in the age of slavery, when messages about black women's lasciviousness went unchallenged.

Enslaved women, whose voices have been muted in medical writings, still managed to name and articulate fully their pain. Some of these women courageously informed doctors in explicit language about their sexual abuse. In

1824, an unidentified enslaved midwife informed Dr. John P. Harrison that her enslaved parturient patient, "A.P.," had been raped and impregnated by a young white man.<sup>10</sup> Harrison, however, did not believe the midwife's account. He wrote in an article published in the *American Journal of Medical Sciences* that no white man would be attracted to a black slave woman who was depicted as a "short, thick-built, chubby creature, with a large head and neck."<sup>11</sup> The crime of rape did not exist for black women during this era. Yet Harrison included the midwife's claim, one he negated, that her patient and fellow slave A.P. had been violated sexually, in the journal article. The midwife might not have been aware of legal statutes concerning rape and black women, but she disclosed all the facts of A.P.'s medical case, which was exacerbated by the violent rape she had experienced.

Bondwomen experienced rape and other types of violent sexual assault frequently. The belief that black women were lascivious was so firmly entrenched in the white psyche that some southern states like South Carolina and Mississippi declared black women could not be raped despite the fact that slave children with white fathers were scattered all over the South. In a famous 1859 court ruling, a Mississippi court declared, "The crime of rape does not exist in this State between African slaves. . . . Their intercourse is promiscuous, and the violation of a female slave would be a mere assault and battery."<sup>12</sup> Celia, a nineteen-year-old Missouri slave woman who had been raped by her owner for five years, murdered him after he entered her cabin to have sex. Her attorneys used a Missouri honor code in her case, arguing that Celia defended her honor against her owner through the use of deadly force. She lost the case and was executed because honor was not a privilege that black and enslaved women could access.<sup>13</sup>

Returning to A.P.'s case, an easy comparison can be drawn between black women's medical experiences and the physical and emotional impact of the kinds of intense physical labor they performed, especially while pregnant. Surely A.P. had to have experienced emotions ranging from anger and frustration to depression and shame because of her treatment by white southern men. The publication of her medical case in a leading medical journal sent a message about black women's honesty, attractiveness, and physicality. Additionally, enslaved women had to contend with the emotional pain caused by rape, disapproving doctors, and difficult pregnancies. Last, for pregnant enslaved women such as A.P., they were also beset by the constant threat that pregnancy and childbirth created: the possibility either they or their babies would die.<sup>14</sup>

What these cases illuminate is that although medicine and law were both sites where "race was made," U.S. medical discourse was capacious enough to recognize enslaved women's rape even when the law did not acknowledge

their sexual abuse. One reason for this disparity is that doctors who treated the enslaved, especially women and girls, were much more transparent about describing the physical and sometimes psychological effects of rape because they could medicalize it. The courts, in contrast, did not consider the traumatic impact of black women's rape because of the prevalent ideologies about black women's immorality, and they were interested almost solely in the possible loss of the slave owner's property. The sociopolitical world of antebellum-era slavery and medicine further ensured that enslaved black women would continue to be regarded as "superbodies."

The rape of enslaved women and girls was a component that aided in the continual debasement of black women in American society. Unsurprisingly, black women and girls were denied legal protection by southern states. Historian Sharon Block has argued in her work on rape in early America that for enslaved girls and women, "continuing sexual abuse was often a fact of life." Additionally, few legal mechanisms existed to protect enslaved girls and women from rape, and this "lack of recourse greatly affected their reaction to sexual attacks."<sup>15</sup> A famous court case that took place in Mississippi in 1859 highlights quite boldly how white people considered rape an oxymoron for black women in early America. The state's court dismissed rape charges against an enslaved man named George involving the rape of a ten-year-old enslaved girl. The judge further declared, "The crime of rape does not exist in this State between African slaves."<sup>16</sup> The state later overturned the ruling and created a law that allowed a "negro" or "mulatto" enslaved child under the age of twelve to have legal protection as a victim of rape.<sup>17</sup>

Whether southern legal systems acknowledged the rape of enslaved women and girls or not, the fact remained that this vulnerable population, their owners, and medical doctors had to confront the physical, medical, and psychic realities of rape in enslaved black women's lives. Slaves were forbidden autonomous mobility; it was illegal without the owner's consent, so most rape victims stayed put. Thus most enslaved girls and women suffered the physical wounds and illnesses brought on by their sexual assaults in sight of their rapists, and there are medical journal articles that reflect this historical fact.

Alongside women in slave communities who provided healing according to the "relational vision of health" that Sharla Fett articulates, a view of healing that was both sacred and secular, medical doctors administered curative work but relied almost exclusively on chemical medicine to heal black women.<sup>18</sup> Black women healers, on the other hand, practiced a relational vision of health anchored in a belief that their healing would be left not solely to human beings but to God and their ancestors. Dreams and signs were just as relevant as any medicine a doctor prescribed, even more so in many slave communities.

The antebellum era was a pivotal moment in the lives of both enslaved black women and white medical men because the landscape for professional women's health care was in flux. There was an emergent class of male midwives, professed experts in gynecology, and also doctors who began to treat women exclusively; their numbers were small but growing. The following case sheds light on the changes that were occurring. While Fanny, a middle-aged slave, was giving birth, both she and the baby she delivered died under Dr. John A. Wragg's care. According to the doctor's subsequent article in the *Southern Journal of Medicine and Pharmacy*, before his arrival a Savannah, Georgia, plantation "Negro" midwife had treated Fanny. Wragg also wrote that the enslaved midwife's assessment of Fanny's condition must "be taken with some degree of caution." He did add, however, that the midwife's story should be thought of as "tolerably accurate and trustworthy" because she was intelligent.<sup>19</sup> Wragg then posed a question that became foundational for how white medical doctors should assess enslaved black women's healing work, even tolerably "intelligent" ones. He asked readers, "Could, or rather would the life of this woman have been saved, had a physician been called in earlier?"<sup>20</sup> His question indicates a shift from the idea and practice that women were the natural caretakers of pregnant women to one where medical men should attend to all births.

The nature of nineteenth-century medicine was mainly exploratory; searching for the root cause of a medical condition, however, especially surgically based research in gynecological medicine, could be exceedingly dangerous for enslaved patients who were subjected to such operations. Once medical training moved from an apprenticeship culture to one that was more scientifically based in the 1800s, medical research became more important to doctors. During the seventeenth and eighteenth centuries, according to Abraham Flexner's influential 1910 report on medical education, medical schools "existed as a supplement to the apprenticeship system."<sup>21</sup>

As gynecology grew, doctors wrote about nearly every manner of women's diseases and conditions in medical journals, thereby extending the reach of medical education beyond schools. As these men engaged in finding cures for women's reproductive illnesses, some surgically based, like the repair of vesico-vaginal fistulae, gynecological medical experimentation increased, especially on enslaved women. In the South, white doctors had a vulnerable and accessible black population on which they could perform operations and test cures. The widely held belief that black women suffered from gynecological diseases disproportionately encouraged such experimentation.<sup>22</sup> Historian William Dosey Postell cites an example of such notions, observing that southern doctors believed that "uterine troubles were of common occurrence among slave women."<sup>23</sup>

Another manifestation of the distinctions that doctors made between the sexuality of black women and that of white women is the different protocol they followed during physical examinations, based on the patient's race. Determining the source of gynecological conditions required that doctors examine black women's naked bodies, even though the practice was rare in medical circles for white women. Medical men generally did not gaze upon their white female patients' once they had disrobed except during emergencies. In contrast, white physicians generally shared the assumption that black women were immodest about the display of their bodies, and medical doctors examined black women's breasts, stomachs, and genitalia without reserve. The history of enslaved black women's handling by white men in the Americas began with the institutionalization of slavery during the early sixteenth century and continued into the nineteenth century. Later, medical doctors were included in the evaluation process and began to examine black women in southern slave markets.<sup>24</sup> Concurrently, as gynecology developed and American medicine was formalized, enslaved women's examinations became part and parcel of doctors' medical work as they assessed black women's economic value.

In 1825, Dr. Finley, of Charleston, South Carolina, published an article that detailed his examination of a bondwoman in her midforties who was "menstruating from her mammae."<sup>25</sup> Although Finley did not indicate whether the enslaved woman's condition was unique, he found it interesting enough to share the case with his peers. He wrote that his patient could not provide an exact date when the discharges had begun; further, she claimed ignorance about the nature of her nipple bleeding. She informed Finley that she suffered pain in her side, experienced anal bleeding, and was fatigued. She stated that above all she wanted to be relieved from her agony. Paradoxically, despite all the symptoms that the enslaved woman shared with Finley, he was unable to diagnose the cause of her condition. He seems not to have considered whether the patient had cancer, a tumor, or even a cyst. Rather, Finley determined that his black patient could experience not only a normal menstrual cycle but also an abnormal one located in her "menstruating breast."<sup>26</sup> The unnamed enslaved patient became another model of black female abnormality, the epitome of the "medical superbody." In her case, her period could be experienced not only in her uterus and ovaries but also in her breast. Although she was not described as freakish, it was clear that Finley regarded her condition as beyond the scope of a "normal" women's disease.

In response to her ailment, Finley petitioned other "professional gentleman of this city" to provide him with information concerning her illness in the *Carolina Journal of Medicine, Science, and Agriculture*.<sup>27</sup> He promised that, in return for the medical services he would render to the enslaved patient, he would allow

his colleagues to experiment on the bondwoman for pedagogical purposes. As his requests reveal, the slave woman's recovery was less critical to the attending physician than the medical lessons he and his colleagues could possibly glean from an observation of her "menstruating" breasts.<sup>28</sup>

James Marion Sims operated as both a doctor and a slave owner. Dr. Sims believed that the survival of black slave women depended on his medical expertise; however, his career proved that the opposite was true: Sims depended on enslaved black women's bodies to discover cures for vesico-vaginal fistulae and perfect surgical instruments such as the duckbilled speculum, achievements that were responsible for his global status as a pioneering gynecological surgeon. As the philosopher Georg Wilhelm Friedrich Hegel observed in *The Phenomenology of Mind*, "The master relates himself to the bondsman immediately through independent existence, for that is precisely what keeps the bondsman in thrall; it is his chain."<sup>29</sup> The enslaved women Sims treated, however, possessed bodies and lives that were not contingent upon the advancement of gynecology. Black women could and did conceive of themselves and their worth without the inclusion of white men.

Black women often continued their midwifery work even after slavery ended, demonstrating they did not want white men's permission, intrusion, and instruction to perform medical work that they believed they had mastered. While enslaved, Mildred Graves labored for decades as a nurse and midwife in Hanover, Virginia, for her owner, Mr. Tinsley. Graves serviced both black and white women because of her reputation as an exemplary accoucheur and "doctoring woman." Despite her position, Graves suffered ridicule and shameful debasement by white doctors. She remembered a particularly traumatic episode when her owner sent her to assist Mrs. Leake, a pregnant white patient who was experiencing a protracted labor. Upon reaching Leake, Graves encountered two doctors from Richmond there to assist in the child's delivery. The doctors informed Graves that they were unable to help Leake. Graves responded, "I could bring her 'roun'." As the bondwoman later recalled, the doctors "laugh at me an' say, 'Get back, darkie. We mean business an' don' wont any witch doctors or hoodoo stuff.'"<sup>30</sup> Leake, however, insisted that Graves deliver her baby, and the midwife did so successfully. Mildred Graves reported defiantly that the doctors who condemned her "said many praise fer [her]."<sup>31</sup>

The enslaved Graves courageously dealt with the doctors' general hostility toward her race, gender, and enslaved status, their mocking of her African-based medicinal knowledge, and their dismissal of her skill set. The obstetrical case allowed her to transcend, momentarily, the marked racial and gendered boundaries set for her in a racially stratified society. Though her white patient

served as the impetus for the exchange to occur, the woman's delivery was as a potent reminder that enslaved doctoring women could rarely escape the white gaze and condemnation.<sup>32</sup>

Another site where enslaved women and white men, doctors and slave owners alike, had contested relations was the area of slave family planning. The sexual abuse that enslaved women endured certainly exacted a toll on their bodies and psyches, but the prospect of becoming mothers could often serve as a powerful antidote to their suffering. Sometimes women received gifts as rewards for "breeding" children. During Mary Reynolds's enslavement, she recalled her owner's promise to give every woman on the plantation who birthed twins within a year's time "a outfittin' of clothes for the twins and a double warm blanket."<sup>33</sup> The owner's incentive for the women to bear twins, as if they could will themselves to deliver multiple children during a birthing session, emphasizes how ignorant some men were about reproduction. Also, the owner's promise of an especially warm blanket reveals the scarcity of these essential items for pregnant enslaved women.

Some bondwomen, like Martha Bradley, struck out at white men who offended them by attempting to suggest they enter into sexual unions. Bradley shared a story with her interviewer: "One day I was working in the field, and the overseer he come round and say somep'n to me had no business say. I took my hoe and knocked him plumb down. . . . I say to Marster Lucas what that overseer say to me and Marster Lucas didn't hit me no more."<sup>34</sup> Her case was highly unusual because of the counternarrative of victimization it provides but also because of the response of her master, who surprisingly ceased whipping her upon learning of the overseer's transgression. Feminist scholar Saidiya V. Hartman posits, "The enslaved is legally unable to give consent or offer resistance, she is presumed to be always willing."<sup>35</sup> Yet Bradley's reaction to Lucas informs scholars that some enslaved women, if provoked, readily used violence as a weapon to protect themselves against men who insulted their moral sensibilities by acting on the assumption that black women wanted to sleep with them. More broadly, historian Stephanie Camp has argued that "for bonds-women . . . intimate entities such as the body and the home were instruments of both domination and resistance."<sup>36</sup>

Martha Bradley's story elucidates the disparate methods some enslaved women employed to claim honor for themselves as protection against sexual dominance and exploitation by men, who often viewed them as hypersexualized. Bradley's recollection of this event to a government worker illustrates two major considerations: First, her case emphasizes that some whites, like Martha's owner, might have believed that black women could indeed possess honor in

their interactions with white men. Second, one can speculate that Bradley offered this story to underscore the meaning she gave to herself in ways that whites did not.

This latter point conveys the role of agency that some formerly enslaved persons sought to insert in the historical record, which reminds us of the importance of historical memory. The übersexuality that white society attributed to the black woman's body has origins that date back centuries. Winthrop Jordan cites an instance of this historical reality, writing, "By forging a sexual link between Negroes and apes, . . . Englishmen were able to give vent to their feelings that Negroes were a lewd, lascivious, and wanton people."<sup>37</sup>

Acts of resistance such as Bradley's offer us insight into the ways that enslaved women actively sought authority over their lives. Independently choosing and maintaining loving relationships with black men was one of the ways black women resisted white control over the most intimate and personal parts of their lives. Lucy Ann Dunn, a North Carolina enslaved woman, articulated powerfully the love she had for her husband, Jim Dunn, and their eight children. Dunn told her interviewer, "We lived together fifty-five years and . . . I loved him durin' life and . . . though he's been dead for twelve years . . . I want to go to Jim . . . when I smell honeysuckles or see a yellow moon."<sup>38</sup> Mrs. Dunn's memories shine a light on the importance of black male and female romantic partnerships during slavery. Also, having children was essential for black women and the black men they loved because it cemented notions of family and self even on a shaky foundation.

Bondwomen's actions and testimonies about reproduction and parenting suggest that some enslaved women defined the terms under which they would both birth and parent "their" children." For example, Mrs. James Seward's sister, also an enslaved mother, claimed ownership of herself and her infant child in direct defiance of her owner's wishes. When the toddler began to walk, her master sold the child. Seward explained that her sister "went and got it [her child]" after the sale was finalized.<sup>39</sup> Her act of defiance alerted her master that her position as the baby's mother would trump any decision he made. Further, she proved she would intervene in the child's life at her discretion.

For those bondwomen who resisted the reproductive control of white men, planned pregnancies were a form of "womb liberation" especially when supportive black midwives offered them prenatal care and used less-intrusive medical treatments. Dellie Lewis, whose grandmother served as a plantation midwife, explained that her grandmother typically gave enslaved obstetrical patients "cloves and whiskey to ease the pain."<sup>40</sup> As gynecology developed, however, white men's intrusion into black women's reproductive lives became even more prominent. The contours of enslavement did not grant bondwomen

the liberty to prevent physicians from performing risky experimental surgeries on them or giving them dangerous drugs for medical complications that often arose in delivery.

The following case elucidates this point. In August 1819, Nanny, a Columbia, South Carolina, enslaved woman, lay in agony for sixty hours because she was unable to give birth naturally. Despite the presence of a slave midwife, her labor could not be induced. Afraid that Nanny and her child would die, the midwife called Dr. Charles Atkins to intervene in this obstetrical case. After Nanny was examined, she underwent emergency surgeries on her bladder, ruptured cervix, and vagina. She endured the surgeries over a two-day period. Nanny was a high-risk obstetric and gynecologic patient because she was carrying twins who had died in utero. Her doctor removed one stillborn child by "hand art" and the other, the second day, with his surgical blade. As risky as antebellum-era surgeries were, Nanny amazingly survived the procedures.<sup>41</sup> Although Nanny represents many antebellum-era enslaved women who lost children during childbirth, the early publication of her medical experiences was not so common.

The nineteenth century was a watershed era in American gynecologic medicine. White men entered a field that had been dominated by women for millennia, but these men also pioneered surgical advances that repaired obstetrical fistulae, removed diseased ovaries, and performed successful cesarean section operations. In the South, as discussed earlier, enslaved women were disproportionately represented in these early surgical experiments. Physicians worked on them in their homes, hospitals, and classrooms. As doctors wrote about black women's diseases and bodies, their colleagues, perhaps inadvertently, learned how to think about and treat black women from medical journal articles. Doctors created a metanarrative about race, ability, and gender that centered on "black" women. This metanarrative might have been peppered with technical jargon about medical procedures, but their writings unquestionably offered an early "technology" of race through medicine. The technology of race was certainly employed in medical journals and the pedagogical framework of medical training taught in medical hospitals because it, as Evelyn Brooks Higginbotham argues, "signif[ied] the elaboration and implementation of discourses (classificatory and evaluative) in order to maintain the survival and hegemony of one group over another."<sup>42</sup> The metanarrative was deeply nuanced not because of its foundation in the politics of race and medical knowledge, always a contentious issue in antebellum America, but rather because much of the metanarrative included enslaved people's voices. When doctors chose to include their voices in medical literature, their testimony revealed deep fissures in the ideology of white Southern paternalism and black people's acceptance of this

so-called benevolence. In numerous medical case narratives, doctors would write about the soundness and strength that black people possessed despite their illnesses and the ease with which black patients managed pain. Yet, in the same narratives, contradictions appeared that revealed black patients' frailties and pains. In Nanny's case, enslaved men and women intervened on her behalf because they witnessed the wasting away of her physical strength and vitality taking place because she "bred" so often.

The narrative of Nanny's medical case exposed the concerns of the enslaved men and women from her community. They informed Dr. Atkins of their feelings about Nanny's physical frailty due to her seven former pregnancies.<sup>43</sup> They declared Nanny should have never been allowed to "breed" because her body was "too delicate." Notwithstanding Nanny's fragility, at least according to the black plantation community, her final prognosis was positive, according to Dr. Atkins. She recovered, having survived a harrowing physical ordeal, and became infertile, a condition that most probably decreased her economic value. Historian Marie Jenkins Schwartz has noted the importance of reproductive health for both the enslaved woman and her master during the antebellum era. She asserts, "A dual approach to the management of women's health developed on Southern plantations."<sup>44</sup> Although black enslaved women and their white male owners were invested in maintaining black women's gynecological health, their reasons and methods varied. Nanny's case demonstrates the saliency of Jenkins Schwartz's argument because it demonstrates how physicians, like slave owners, were similarly invested in highlighting black women's "difference" and thus their "inferiority" to white women. Despite her extensive surgeries, seven in all, Nanny's quick recovery postsurgery and subsequent good health and strength seemed to prove the hardiness of black women, especially those "fit" for labor like bondwomen.

American medicine developed under the expansive influence of European scientific racism. As a consequence, early gynecologists demonstrated their medical knowledge through their treatment of and writings about enslaved women as gynecological patients who purportedly felt little or no pain as they underwent invasive surgical procedures.<sup>45</sup> Antebellum-era doctors continued the American tradition of reinforcing prevailing racial stereotypes about "black" women through their writings. These men recognized the importance of medical journals, especially as the field became more legitimized.

As the field of gynecology emerged, enslaved women had to learn to manage growing medical intrusions into their sexual lives, interference that often made them ill. Enslaved women were often forced to have intercourse with men whom their owners chose for them to "marry." In an interview years after she was freed, Marriah Hines noted that her master had married her to a man of his

choosing, and she had "five chullun by him."<sup>46</sup> In cases where women birthed children from rape or were forced to rear children whom they had not borne, they faced a host of complex issues. More amazingly, how did enslaved women negotiate their paths inside the brutal terrain of slavery and maintain a firm hold on their sanity? Bondwomen's insistence on exercising reproductive autonomy helped form what might be called a liberation doctrine, one that stressed their humanity, strength, resiliency, and intelligence. Their metalanguage, "language that supersedes multiple categories of difference," was contained within their acts of resistance and survival.<sup>47</sup>

When Marriah Hines mentioned that her owner married her to a man for whom she bore five children, she also acknowledged that she learned to love and celebrate him. Hines stated that her husband was "one of the best colored man in the world."<sup>48</sup> The larger issue of brutality cannot be overstated when we examine how masters took away enslaved people's right to choose who they desired romantically. Yet even in the context of Hines's dehumanization, she chose to celebrate her husband's manhood and her love for him. Black women's ability to love romantic partners forced on them was very similar to their choosing to love children resulting from rape or to nurture those they were forced to raise after the children's parents had been sold away. Bondwomen's resistance must be read as a central theme critical to understanding the totality of their lives even as they lived within the restrictive contours of slavery and professional medicine. Unfortunately, although gynecologists sometimes included enslaved women's words in medical narratives, their metanarrative of race and medicine did not take into full account black women's metalanguage of race. Thus historians of slavery and medicine must continue to examine and interpret how enslaved women responded to the medical treatments and behavior of doctors and slave owners, keeping in mind that these sources were authored solely by white men.<sup>49</sup>

Metanarratives about black women's bodies, health, and responses to white people's medical interventions also crossed gender lines. White plantation women sometimes recorded how black women responded to their illnesses and treatments in their personal writings. Noted diarist and former Georgia plantation mistress, the English-born actress Frances Kemble detailed how her husband, Pierce Butler, routinely treated sick bondwomen on his plantation. Kemble documented a troubling incident that involved Teresa, a woman they owned. She wrote, "With an almost savage vehemence of gesticulation . . . [Teresa] tore her scanty clothing, and exhibited a spectacle . . . which inconceivably shocked and sickened. . . . These are natural results, inevitable and irremediable ones, of improper treatment of the female frame."<sup>50</sup> Kemble sympathized with Teresa's pain but also expressed her simultaneous amazement

and repulsion at the woman's appearance and behavior. Equally distressing to Kemble was her husband's ability to carry on his daily duties with neither interruption nor concern for Teresa. Slavery created a space where white people could witness the most horrific acts of sheer brutality and viciousness against other humans, and without a misstep, they could make love, go to church, and kiss their children good night.

Parthena Rollins, an ex-slave from Kentucky, experienced the macabre nature of slavery's brutality and hesitated to discuss her experiences under the institution nearly seven decades after its abolition. She shared that the abuses she and other slaves suffered in bondage by stating plainly to her white interviewer that what black slaves endured "would make your hairs stand on ends."<sup>51</sup> Rollins recalled the murder of an enslaved infant before its mother. Slave traders came ready to purchase the seemingly robust and strong young mother; however, they were adamant about not buying her baby. The woman's owner, wanting to make a sale, quickly beat the child until it died.<sup>52</sup> After her sale, the slave woman began to have seizures. According to Rollins, the woman's "fits" were brought on by her child's cruel murder. In another act of cruelty, her new master refused to pay the costs involved in providing the bereaved mother with necessary medical treatment and instead returned the woman to her former owner and asked for a full refund. Rollins declared finally, "She could hardly talk of the happenings of the early days because of the awful things her folks had to go through."<sup>53</sup>

Although enslaved mothers were aware that they could be sold away from their children, they were not prepared to deal with the murder of their offspring and the trauma following these painful occurrences. Although Rollins's example is rare, it is deeply significant because of its bold example of black women's intersecting experiences with sexuality, reproduction, economic value, death, and medicine.

Enslaved mothers often went to great lengths to protect their children from the excessive violence of slave owners and overseers. In doing so, these bond-women arguably fashioned a form of honor unique to their experiences as reproductive laborers. Fannie Moore offered a moving testimony of maternal protection, describing the punishments that her mother would often suffer to shield her children from the brutality of the plantation overseer. Speaking of her mother with pride, Moore stated, "She stan' up fo' her chillun tho'. De ol overseeah he hate my mammy, case she fight him for beatin' her chillun. Why she git more whippings for dat den anythin' else. She hab twelve chillun."<sup>54</sup> As the reaction of Moore's mother reveals, some enslaved women were willing to attack white men for viciously abusing their children, regardless of the violence inflicted on their own bodies.

The narrative of Canadian refugee Mrs. John Little provides a deeper view of how enslaved women fought back through silence, suffering, and ultimately cunning. She shared her story of being a member of a contingent of Virginia slaves who crafted an escape plan, which initially failed because of the betrayal of a group member. For the two women involved, sex and reproduction were connected to their punishments when caught. Mrs. Little stated, "The master made a remark to the overseer about my shape. Before striking me, master questioned me about the girl. . . . I only knew that she had been with child, and that now she was not, but I did not tell them even of that. I was ashamed of my situation, they remarking upon me."<sup>55</sup> The other woman Mrs. Little mentioned received an abortion from an enslaved woman who was made aware of their escape plan. Perhaps it was an enslaved midwife who provided Little's comrade with the abortion, but all the women decided it was the most appropriate medical action to take before they escaped.

The work of renowned natural scientist Louis Agassiz stands as a testament to how black women lacked control of their bodies and images in almost every conceivable way. Drana was an enslaved South Carolinian whose father was Congo born. Agassiz commissioned South Carolina daguerreotypist J. T. Zealy to capture Drana's image for observation and educational purposes. Agassiz was a firm believer in polygenism, the theory that racial groups did not share a common ancestor as the Bible asserted, and these pictures would help to prove the validity of his belief.<sup>56</sup> Drana was photographed both frontally and sideways with her breasts bared. It was clear that these daguerreotypes were meant to document black people as scientific specimens, wholly distinct from white people. Figure 3.1 is a daguerreotype taken in 1850 when the emergence of Americans interest in scientific racism had crystallized with the emergence of the American school of ethnology, advanced by physicians Samuel Cartwright and Josiah Nott and early ethnologist Samuel Morton, among others.<sup>57</sup> The American school was decidedly antiblack.

In slavery and in the annals of antebellum-era medical education, the representations of and writings about the black female body had been used to shame black people. Further, these writings situated black women as the diametric opposite of white women, who, though still viewed as the abnormal sex, were considered virginal and virtuous. Slave owners and medical doctors inscribed the enslaved black female body not only to reflect gendered notions of racial resiliency but also to aid in the commodification of slavery. Enslaved women's anatomies would determine if an owner's wealth increased through her sale or whether a physician's good reputation stayed intact, and her fertility could supposedly be determined by the appearance of her reproductive organs. In the North, however, another dispossessed group of women shared similar medical



FIGURE 3.1. Daguerreotype of Drana, a South Carolina slave,  
by J. T. Zealy, commissioned by Louis Agassiz, 1850.  
Courtesy of the Peabody Museum of Archaeology and Ethnology,  
Photographic Archives Collection, Harvard University.

and racialized experiences: poor Irish immigrant women. If there was one thing that linked the medical experiences of enslaved and Irish women, it was the notion that blackness, the ultimate mark of difference and inferiority in America, could be mapped onto bodies that were deemed degraded. Between 1800 and 1865, an important historical period in the development of modern gynecology and obstetrics, medical and scientific research on the racialized body reached its apogee.

## CHAPTER FOUR

### IRISH IMMIGRANT WOMEN AND AMERICAN GYNECOLOGY

Oh brave, brave Irish girls,  
We well might call you brave  
Should the least of all your perils  
The Stormy ocean waves.

—James Connally, *Labour in Ireland*

Accordingly it is found, that the patients generally are irregular and careless in their attendance, and pay but little attention to direction. The greater part are extremely ignorant.

—William Buell, writing on the behavior of his  
poor Irish immigrant patients

THE GYNECOLOGICAL EXPERIENCES OF IRISH IMMIGRANT WOMEN IN America began following the transatlantic voyages they took after they fled Ireland because of a potato famine that left them and their nation hungry and desperate. Their sexual exploitation, however, began before these ships reached their destination. Like African women who were forced to board slave ships for the Americas three centuries earlier, nineteenth-century Irish immigrant women also suffered sexual abuses on "coffin ships," so named because of the number of people who died during oceanic voyages to America. The thousands of Irish women headed to the United States were young, alone, and unprotected as they traveled aboard these vessels. For those women who were sexually abused, the boats represented floating prisons where they were un-

TABLE 4.1 Number of Reproductive and Sexually Transmitted Illnesses in Greater New York City

Institutions	Cases
Penitentiary Hospital, Blackwell's Island	2,090
Almshouse, Blackwell's Island	52
Workhouse, Blackwell's Island	56
Penitentiary, Blackwell's Island	430
Bellevue Hospital, New York	768
Nursery Hospital, Randall's Island	734
New York State Emigrants' Hospital, Ward Island	559
New York Hospital, Broadway	405
New York Dispensary, Centre Street	1,580
Northern Dispensary, Waverly Place	327
Eastern Dispensary, Ludlow Street	630
Demilt Dispensary, Second Avenue	803
Northwestern Dispensary, Eighth Avenue	344
Medical Colleges	207
King's County Hospital, Flatbush, Long Island	311
Brooklyn City Hospital, Brooklyn, Long Island	186
Seaman's Retreat, Staten Island	365
<b>TOTAL</b>	<b>9,847</b>

Source: Sanger, *History of Prostitution*, 593.

Unfortunately, the statistical data on the medical lives of Irish-immigrant women is scant when compared to the data on enslaved women, and the reliability of these figures is problematic for many reasons. Despite the ambiguity of Sanger's figures on racial identity and disease, they still provide enough information for contextualization. Poor and immigrant communities were frequently overpoliced, and their members were incarcerated more often than the general population. The figures reported do not provide an exact calculation of how many of these patients were Irish born. However, with the disproportionate number of Irish women who were imprisoned because of prostitution, it is likely that a large percentage of these prisoners were of Irish descent. Further, these alarming statistics point to the roles and growing importance of medical professionals who treated women suffering from sexually contracted infections and reveal how poor white women's sexual labor was linked not only to vice but to disease.

Irish immigrants were familiar with dehumanizing descriptions of them that compared them to Africans and apes. In essence, they were used to anti-Irish Anglo racism, and connections were constantly made through public

discourse and in the writings generated in the medical and scientific worlds to illustrate the limitations of their whiteness and the relative close ties they had with blackness. As anti-Irish and antiblack racism gained a larger platform, obstetrics and gynecology became another area where white antebellum-era medical men could make claims about gender, difference, and race with scientific authority.

During this same era, the entrance of American gynecology as an emerging medical specialty dependent on women's sick bodies made Irish-born women an attractive patient population for northern-based doctors who had begun to work primarily on women. Some gynecologists like James Marion Sims, who had previously worked within slave communities, extended their surgical work to include Irish women in the charity wards of northern hospitals. For southern migrants like Sims, it was not much of a stretch to treat poor Irish women patients as he had enslaved women because much of the Anglo world's racial science, popular literature, and racially biased views of this group held that Irish women were able to withstand physical pain just as black women could.

The case of Mary Smith, Dr. Sims's first New York State Woman's Hospital patient, exemplifies how poor Irish women had to navigate a medical system in which doctors explained women's biological sicknesses in ways that also gave meaning to women's nature and the world men and women occupied. Medical historian Charles Rosenberg states, "Explaining sickness is too significant—socially and emotionally—for it to be a value free enterprise."<sup>15</sup> Dr. Sims's Woman's Hospital could not be a neutral healing space, for it separated rich women from poor women and endowed only men with the liberty to become experts on women's diseases. When Sims asserted that the New York hospital would become "a place in which [he could] show the world what [he was] capable of doing," he was also claiming that his hospital would serve as a site for his personal and professional aggrandizement.<sup>16</sup>

Mary Smith was an Irish immigrant from western Ireland, the country's poorest region, and had arrived in New York as a single mother and a poor sick woman. She would come to represent thousands of poor Irish immigrant women who were connected to New York City's hospitals. Historian Bernadette McCauley states, "By midcentury, the patient population at city hospitals was overwhelmingly foreign-born. . . . By 1866, more than half the admissions had been born in Ireland."<sup>17</sup> Hospital administrators, some of whom might have harbored nativist sentiments against foreign patients, sometimes created hostile environments for Irish immigrant patients like Mary Smith. One Massachusetts General Hospital trustee member claimed that the Irish, as a group, were ignorant and unappreciative medical patients.<sup>18</sup> He stated, "They cannot appreciate & do not really want, some of those conveniences which would be

deemed essential by most of our native citizens." He believed that sick Irish men and women would be more comfortable and appreciative if they were treated in a "cheap building" instead of more expensive and well-maintained hospitals.<sup>19</sup> Living in 1850s New York City, Smith had to have been aware of anti-Irish sentiments held by New Yorkers, and perhaps because the Woman's Hospital was new, she sought services from a hospital that did not have a history of anti-Irish nativism.

As a homeless and sick immigrant woman with severe gynecological ailments, Smith sought treatment in the charity ward of the newly opened Woman's Hospital of the State of New York in 1855. Her name was the first one listed in the hospital's admittance records.<sup>20</sup> Smith developed her reproductive and gynecological conditions in Ireland. She had first given birth at twenty-one years old, and she described both her labor and delivery as difficult. By the time she immigrated to Manhattan, complications from her earlier delivery had caused Smith to develop the worst case of obstetrical fistula that Dr. Sims had ever seen. While performing a pelvic examination on Smith, Sims and his protégé, Thomas Addis Emmet, noticed a strange mass in her upper vaginal area. The surgeons excised a fishing-net covered wooden ball, used as a pessary, from her scar tissue. The ball, which had been inserted while she lived in Ireland, was used to keep her fallen womb inside her body. Additionally, she had a herniated bladder that had also prolapsed. She had become incontinent, her vulva had been rubbed raw because of urine leakage, and her stench, caused by rectal and vaginal incontinence, made her a "most offensive and loathsome object," according to Sims.<sup>21</sup>

As he had during the mid- to late 1840s with his enslaved experimental patients, Sims operated on Smith numerous times without anesthesia in front of many onlookers. In Smith's case, Sims and Emmet performed thirty surgeries on her over a period of six years. Although Sims left the country in 1859 to perform gynecological surgeries such as clitoridectomies in Europe, his junior colleague, Thomas Emmet, continued to work on Smith until the early 1860s. Over this period of time, Sims operated on Mary Smith even more frequently than he had on his enslaved patients. Additionally, Smith was allowed to work in the hospital performing menial labor just as Sims's enslaved patients worked under his watchful eye in the Alabama fistula-repair hospital he had built for them.

As a southerner and former slave owner, James Marion Sims, along with his Virginia-born junior colleague, Thomas Emmet, was familiar with surveilling women's bodies, especially those who fell outside the bounds of racial and class normativity.<sup>22</sup> As in Alabama, Sims eventually lost the support of his community at the Woman's Hospital, particularly fellow doctors and board members.

doctors treated and wrote about black and foreign-born women without thought to their sensibilities. In journal articles, black and Irish women served as flesh-and-blood symbols of biological abnormalities linked to race. This act of framing was a function of the social process of not only defining difference but also identifying how to respond to “otherness.” As a medical doctor, Dexter could link disease to socially unacceptable behavior such as masturbation, a “capricious” attitude, and even running away from home secretly. Although he and his peers relied on masturbation to cure this woman, in Dexter’s article, only the patient was deemed sexually deviant. However, the tenor of these men’s writings reflects their belief that racial difference existed between them and the patient. Also, at the heart of the doctor’s anger over his patient’s running away from home was his consternation that he could not continue treating her and could only guess the specific causes of her condition and not name it definitively. As medical historian Charles Rosenberg argues, “If it [illness] is not specific, it is not a disease, and a sufferer is not entitled to the sympathy . . . connection with an agreed-upon diagnosis.”<sup>39</sup>

Medical journals and the rise of gynecology allowed a new group of professionally trained doctors legitimate spaces to introduce and strengthen their racialized attitudes concerning the medical lives of racially stigmatized people and their supposed pathologies. Specifically during the antebellum era, an emergent class of gynecologists and other doctors integrated science and biology as they framed and defined diseases, gynecological ones included. Through their medical practices and professional writings, they began to define medicine. Medical educator Alan Gregg describes these men’s work as “the study and application of biology in a matrix that is at once historical, social, political, economic, and cultural.”<sup>40</sup>

As scientific racism became bio-racism, many early American gynecologists were participating in creating theories about race and gender, especially about black and white women although they knew that these women’s physical bodies were intrinsically the same. Bio-racism integrated both medical and scientific research to prove how biologically distinct black and white people were from each other. Antebellum-era white supremacy did not allow a space for one to address this kind of racialized cognitive dissonance. For example, Charles Meigs, a noted Philadelphia gynecologist, shared with his students the following assessment of women via his published lectures. He stated that a woman was “a moral, a sexual, a germiferous, gestative and parturient creature.”<sup>41</sup> Although he did not describe women racially, the racial climate and etiquette of the day dictated that he was referring to the white woman as the universal representative model for all women. Yet it was the preserved womb of a black cancer victim that Meigs displayed in his Philadelphia museum as a

teaching tool for his colleagues to learn how cancer affected all women’s uteri. The universal template for woman might have been white, but the fluidity of nineteenth-century racial categories could expand to include whoever fit a doctor’s medical needs at any given time.

Pioneering gynecologists like Meigs knew the importance of medical writings within society. Their publications helped their peers understand the varied medical experiences of Irish women. Historian Alan Kraut has reported how doctors compared Irish immigrant women patients to other European immigrant women. One doctor wrote, “Germans were praised [because] . . . they seemed ‘docile and affectionate’ to the doctors . . . the reverse was said of the Irish.” Another doctor described a mentally ill Irish patient as having “nymphomania,” and he linked the disorder to her morality. He described her as “vulgar,” just as Dr. Dexter characterized his Irish teenage patient as immoral.<sup>42</sup> Clearly, the public nature of these women’s sexual behaviors made them easy targets for doctors to moralize against them. Medical men also knew that these women were not “normal” by nineteenth-century definitions, and yet these women were further penalized for their Irishness.

These medical journal articles also inform scholars about how indigent Irish-born women made decisions about their bodies and responded to medical procedures they underwent as a result of lengthy hospital stays. In 1844, C.C., a nineteen-year-old pregnant woman, was admitted to the Philadelphia Almshouse and Hospital to deliver her child. Dr. George Burnwell, the physician who treated her, described C.C. using three adjectives, “short, stout Irish.”<sup>43</sup> Arguably, Burnwell used a lexicon that linked race and class and inferred that despite the obstetrical problems that the pregnant teenager might have had, as an Irish woman, she was strong and healthy. C.C. represented a flesh-and-blood metonym for the urban white scourge: she was a poor, unmarried Irish woman who relied on charity during her pregnancy and childbirth.

Nineteen hours passed, and C.C. had still not given birth. Alarmed, doctors bled the young woman and administered ergot, a rye-based pharmaceutical that was used to induce uterine contractions during deliveries. After two days, Dr. Burnwell knew that C.C. would deliver a stillborn baby; he had to surgically remove her fetus. Immediately after he began the procedure, the young woman’s “uterus fell away,” and doctors administered stimulants to revive her.<sup>44</sup> She entered the hospital to give birth and left the building childless and sterile.

Like C.C., Irish immigrant women created and responded to the interventions made into their medical lives in various ways. Some obtained professional medical help, some entered the field of nursing, some relied on home-based traditional medicines, and some sought solace away from the formal medical gaze of white men. It is important to understand this group of women within the

context of a comparative medical model that highlights how modern American gynecology impacted their lives. Historians of the antebellum era have drawn comparisons between the oppression of enslaved people of African descent and that of poor Irish immigrants for several generations in their scholarship on whiteness, race, politics, and identity. This scholarship has centered on the development of black and Irish nationalism, the political economy of slavery, and the wage slavery that recently immigrated Irish laborers suffered under during the nineteenth century. Yet the medical lives and experiences of Irish immigrant women were not parsed for careful analytic review.

Labor relations were sometimes present in boss-doctor-patient exchanges. It was a common practice that employers intervened on behalf of their domestic servants if the women were exceedingly ill. During the mid-1860s, Mary McC.'s boss sent the twenty-one-year-old Irish cook to be examined by leading gynecologist Dr. T. Gaillard Thomas at either Bellevue or Charity Hospital in New York City.<sup>45</sup> How could Mary McC. decline the services of Dr. Thomas if she had no initial say in selecting him as her physician? Young Irish immigrants did not have a long American culture of traditional and naturalistic health care as did enslaved women. Clearly, when writing about the ethical policies that governed doctor-patient relationships, the AMA conveniently imagined patients as either white men or white women. The poor and immigrants who were relegated to tenement living seemed not to be considered by doctors; they lay outside the power structure where medical men could only negotiate and barter power with white men and perhaps elite white women.

The starker difference that existed in the treatment of these enslaved black women and Irish immigrant women lay in what happened to them after their surgical encounters. As their sick bodies were healed, black women returned to slave communities to toil. Poor Irish women's improved health status allowed them to continue to work for wages as free women. Thus, the development of the domestic service industry in northeastern cities like New York and Boston has a direct link to the work of early gynecologists. These men were responsible for "fixing" Bridget's body ("Bridget" was a derisive name for Irish women).

Irish women who married and gave birth to children were afforded opportunities to improve their lots in life because they were not owned, no matter the dire circumstances they faced. They did so by vending, educating their children, and marrying native-born American white men. Many second-generation Irish women became nurses and teachers because of the efforts of their mothers. Further, the American-born daughters of Irish immigrant women did not face the risks of sexual abuse that occurred aboard ships sailing from Ireland to America. This situation also heightened the differences between the daughters of poor immigrants and enslaved women. Enslaved

girls would always be subject to the same abuse that their mothers had suffered and could not rely on education to better their situation. Although many Irish immigrant servants, like their enslaved sisters in the South, were at the mercy of sometimes-unscrupulous employers who took advantage of them sexually, the fact remained that Irish immigrant women could choose to leave their employers. Throughout northern cities, the number of Catholic-run charitable organizations located in Irish tenements directly dealt with issues of sexual abuse. Slave women did not have the same kind of formal mechanisms in place to deal with complex and damaging issues like rape and molestation by their owners.

Irish immigrant women also relied on the Catholic Church to be involved in their healing. The reality for this group of women was that, unlike enslaved women, they could integrate their religious beliefs into the formalized hospitals they used. Irish Catholic sisters and the subsequent charitable organizations that they ran created "cultural sites" for healing to occur. To combat nativists' beliefs that the Irish would be "a permanent dependent class in America," these Irish-Catholic spaces proved that Irish-born women could be enterprising, productive, and "clean" citizens.<sup>46</sup>

Sick women who battled gynecological illnesses or who had complicated pregnancies were often at the receiving end of doctors' maltreatment. Mary Donovan, a pregnant woman with a spinal deformity, was one of those whom Dr. George Elliot, a Bellevue Hospital physician, recognized as needing his medical assistance. Elliot treated her in March 1857 and published a medical article about her birthing process with language bloated with descriptors that demeaned her body, intellect, class, and ultimately her race. While the doctor might have simply written clinical notes in dry and apolitical technical language, Elliot's records of Donovan's case demonstrate just how pervasive nineteenth-century ideas about biological differences were in women's medicine.

Elliot first wrote his patient's name, Mary Donovan, and the second word he used to describe her was "Irish." He observed that the thirty-year-old first-time mother "attracted [his] observation . . . by her deformity." After querying Mary for a few minutes about her pregnancy and her spinal deformity, Eliot determined she was a woman who possessed a "very low order of intelligence" and was "apt to exaggerate." Eliot wrote that most of the pregnant women in the charity lying-in ward, where Donovan was hospitalized, lied about the dates they had become pregnant so that they could keep receiving "charity."<sup>47</sup>

After Donovan was informed that she would probably endure a difficult delivery, she gave Elliot her consent to quicken her delivery by administering a warm-water douche to induce labor. The doctor initially wanted to administer carbolic acid gas but decided against it due to time constraints. (Doctors in the 1850s used carbolic acid gas for the "treatment of painful affections of the

uterus" and to "induce artificial *accouchement*" or labor.)<sup>48</sup> Once the treatment began, Donovan offered "insane struggles" to stop the douching. She fought so vigorously to release herself from the restraints of the medical staff that Elliot finally administered chloroform to calm her.<sup>49</sup> After two days of the douche treatment, Donovan delivered a son on March 23, 1857, but he died a few hours later.<sup>50</sup> During Donovan's treatment, four other doctors observed her along with Elliot. Her case was later used as a pedagogical tool in the pages of *New York Medical Journal* so that other physicians could learn how to perfect his douching method on other pregnant women. Elliot described Donovan as a patient who was violent, dumb, and defective, but her body provided a pathway for doctors to learn more about all laboring bodies even though she lost her baby in the process of his treatment.

Some Irish immigrant women acted outside gendered ideals and possessed physical abnormalities that encouraged doctors like Elliot to use women such as Mary Donovan to establish a race-and-religion-specific matrix that exceptionalized poor Irish-born women. Descriptions of Irish immigrant women in the medical literature are remarkably similar to the way doctors wrote about enslaved women's bodies; black women were either amazingly strong or weakened when "white" blood was apparent. The *Georgia Blister and Critic*, an antebellum-era medical journal, published an excerpt of *Types of Mankind*, a book about mulatto women authored by controversial physicians Josiah Nott and George Gliddon. The article illustrates how some physicians used their writings to promote scientific ideas about biological distinctiveness. Nott and Gliddon wrote "that the *mulatto women* are peculiarly delicate, and subject to a variety of chronic diseases. That they are bad breeders, bad nurses, liable to abortions, and that their children generally die young."<sup>51</sup> One Irish physician wrote about the so-called peculiarities of pregnant Irish women in the *Boston Medical and Surgical Journal*. He urged doctors to rely on the traditional practice of bloodletting on pregnant Irish women because of "the strong, almost insurmountable obstinacy of the Irish with us."<sup>52</sup>

Some Irish immigrant women were like Eliza B., a thirty-five-year-old Irish nanny who suffered from gynecological ailments but resisted the absolute authority of medical doctors.<sup>53</sup> Eliza, who was single, suffered from the pain of an enlarged ovarian cyst for eighteen months. Her attending physician, Dr. T. Gaillard Thomas, one of the country's leading gynecologists, initially described her as possessing a "morbid disposition." The first physicians she saw misdiagnosed her as being pregnant. Eliza B. lived with severe abdominal pain for two years. Perhaps her "morbid disposition" arose from the fact that doctors initially dismissed her pain. She finally checked into a hospital on November 1, 1862, and agreed to undergo an ovariotomy.<sup>54</sup>

The medical case of Mrs. F., a thirty-five-year-old mother of three who lived in Philadelphia, demonstrates how Irish immigrant women relied on each other and asserted their autonomy in obstetrical and gynecological cases.<sup>55</sup> Apparently very busy, Mrs. F. experienced a violent fall as she held her "quite heavy" infant while she attempted to use her chamber pot.<sup>56</sup> Unfortunately, she was well into her fourth pregnancy. Dr. Gegan visited her on the morning of January 30, 1859, to examine her. She had lain on her right side for twelve hours because she was in such immense pain, was weak, and was vomiting. During his visit, he determined that she must have ruptured her uterus even though he "could not reach the os uteri [cervix opening]."<sup>57</sup>

At one o' clock the next afternoon, Gegan asked if Mrs. F. believed that her child was alive. She stated, "I feel it all the time."<sup>58</sup> After the physician left, she called her circle of women friends to nurse her during his absence and also to provide community care during her medical crisis. Trusting her five friends to safely change her position in the bed, Mrs. F. asked her them to physically turn her body on her left side. Upon Dr. Gegan's arrival that night, she hastily offered an excuse for why her friends were lifting her; she allegedly felt "much better" and no longer suffered from "soreness on the right side."<sup>59</sup> A few hours before her death, Mrs. F told the doctor that "she could distinctly feel the child move."<sup>60</sup> Shortly after 7:30 P.M. on January 31, 1859, Mrs. F. died.

Dr. Gegan noted that the late patient's husband was quite moved by his wife's statement. The doctor remarked that Mr. F. agreed, only after his wife's death, "that I should attempt the removal of the child, by abdominal incision."<sup>61</sup> Dr. Gegan respected the husband's wishes regarding the performance of an autopsy. The politics of nineteenth-century respectability were being performed fully. Women were almost always seen as meddlesome when involved in male affairs, yet the doctor allowed "four or five" of Mrs. F.'s women friends to comfort her even while he was present. The doctor treated his Irish patient as a white "lady" for reasons he did not disclose, but one can assume she was accorded respect because she was married and perhaps so desperately wanted her child to live.

In another obstetrical case involving an Irish immigrant obstetrical patient, surgeons at the Philadelphia Hospital aided "Alice Mailey during her delivery." In 1859, Mailey was placed under the care of nurses and physicians at the Nurse's Home.<sup>62</sup> She was twenty-nine years old, unmarried, primiparous, and considered healthy. Like the pregnancies of many women of the time, however, Mailey's became complicated. She was placed under the care of Dr. D. Hayes Agnew, one of the nation's leading surgeons. In a medical journal article, Agnew described Mailey's childbirth as "severe."<sup>63</sup> During her protracted delivery, her uterus "ruptured," and the fetus shifted "into the abdomen."<sup>64</sup> The

baby was delivered stillborn, and the mother was left with a “rent in the uterine walls” that had “extended through the cervix, and involved the vesico-vaginal fistula septum, giving rise to a fistula [hole].”<sup>65</sup> Agnew operated on Mailey four times, first at the Nurse’s Home and later at Saint Joseph’s Hospital, for the repair of her vesico-vaginal fistula.<sup>66</sup> After Mailey’s recovery, Agnew reported that she not only “enjoyed comfortable health” but also was “able to support herself as a servant in a private family.”<sup>67</sup>

These immigrant women’s medical experiences show the range of treatment that Irish women received from doctors, from sympathetic to bigoted, and highlight some of the differences between their situations and that of enslaved women. Whiteness was extended to Alice Mailey, Eliza B., and Mrs. F., an act that no enslaved woman was ever given in the antebellum era.

By the early 1860s, as political definitions of blackness and whiteness were becoming firmer, native-born white Americans began to slowly extend a few privileges of whiteness to Irish women. However, early gynecologists were still writing about their bodies as if they were more “colored” than white. As Americans continued to cultivate their brand of nationalism, medicine and medical writings served as sites where race was being reified. After the Civil War, legislators in the former Confederate states created Black Codes, laws that used language from scientific racism to distinguish black people, white people, and “mulattos” from each other. Gynecologists who wrote about biological differences helped to create the environment from which those racist laws sprang. In their writings, they proclaimed that elite, native-born white women were fragile, normal women. Irish and black women, in contrast, were described as physically stronger and more sexual, and they were believed to suffer reproductive ailments at different rates than white women did. It was a nearly universal belief that black women and Irish women were more fertile than their white counterparts. Early gynecologists continued to promote the idea that these women were apelike and “more suitable” for gynecological experiments than white women.<sup>68</sup> Historian Laura Briggs has noted the contradictions in early gynecologists’ writings about immigrant women and black women, who were supposed to have easier childbirths. Early gynecologists’ writings featured Irish women who had protracted labors that lasted for days and were so difficult that medical men were involved, an unusual practice during the nineteenth century.<sup>69</sup> Often Irish women were mentioned in articles about the effects of multiple births. Dr. William Potts Dewees, one of the country’s most prominent obstetricians, saw one married Irish woman, Mrs. Haley, in July 1830 and detailed her fecundity and gynecological conditions. Haley was sixty years old, the mother of sixteen children, and apparently was still suffering from her many pregnancies. Potts Dewees wrote that his patients had

“suffer[ed] 3 abortions, early labour . . . she ha[d] suffered with the present prolapsus the past 6 years.”<sup>70</sup> Regardless of the contradictions they contained, medical writings about immigrant and black women represented one of the most popular sites for ideologies about black and white biological distinctions to be introduced and discussed.

Medical doctors and scientists who researched biological differences among the “races” connected Irish women to black women for reasons ranging from their supposed superior physical strength to their fecundity. By the end of the nineteenth century, physicians like Lucien Warner were thoroughly convinced that black and Irish women shared the same reproductive capabilities and superior health. Warner posited, “The African negress, who toils beside her husband in the fields of the south, and Bridget who washes, and scrubs, and toils in our homes at the north, enjoy for the most part good health, with comparative immunity from uterine diseases.”<sup>71</sup>

Gynecologists’ construction of black and immigrant women’s reproductive bodies as “medical superbodies” was a means to make sense of these women medically and also a rationale for how they were to be treated outside medical spaces. As noted in an earlier chapter, James Marion Sims’s father expressed disappointment with his son’s decision to pursue medicine. He believed there was no science, respect, or honor in the field. So for men like Sims who were as committed to healing patients as they were to establishing respectable, honorable, and lucrative careers, more than medical knowledge was at stake. They were contributing to the greater good by using bodies that were “fit for labor” to heal all bodies. Black lives mattered medically because they made white lives healthier and better. It was important for journal readers to know how these women, the unrecognized and often unnamed “mothers of gynecology,” responded to examinations, surgeries, experimentations, and even recovery because this knowledge enabled white men to more easily grasp science-based theories that explained why blackness, and to a lesser degree, Irishness, was so strange and pathological. The addition of disenfranchised Irish immigrant women to biomedical explorations of racial otherness did not explode existing categories but rather continued discussions about these women as one-dimensional objects to be understood without nuance. The medical narratives that were created based on these women’s gynecological treatment helped to further perpetuate the uneven cultural productions on biologically based racial difference. Racial categories were still being processed in the antebellum era, but modern American gynecology’s growth worked to lay a foundation on which both blackness and whiteness would be defined as separate and unequal for generations. The black female body was central to these discussions and medical knowledge productions.

The accomplishments of pioneering American doctors such as John Peter Mettauer, James Marion Sims, and Nathan Bozeman are well documented. It is also no secret that these nineteenth-century gynecologists performed experimental cesarean sections, ovariectomies, and obstetric fistula repairs primarily on poor and powerless women. *Medical Bondage* breaks new ground by exploring how and why physicians denied these women their full humanity yet valued them as “medical superbodies” highly suited for medical experimentation.

In *Medical Bondage*, Cooper Owens examines a wide range of scientific literature and less formal communications in which gynecologists created and disseminated medical fictions about their patients, such as their belief that black enslaved women could withstand pain better than white “ladies.” Even as they were advancing medicine, these doctors were legitimizing, for decades to come, groundless theories related to whiteness and blackness, men and women, and the inferiority of other races or nationalities. *Medical Bondage* moves between southern plantations and northern urban centers to reveal how nineteenth-century American ideas about race, health, and status influenced doctor-patient relationships in sites of healing like slave cabins, medical colleges, and hospitals. It also retells the story of black enslaved women and of Irish immigrant women from the perspective of these exploited groups and thus restores for us a picture of their lives.

“Working at the intersection of race, class, gender, and health, Cooper Owens presents a crucial platform for future researchers. This an intensive and sometimes uncomfortable read.”—*Sarasota Herald-Tribune*



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